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Working Party on the Information Economy

The Kotitori Integrator of Home Care Services in Finland

12-13 June 2012

This document is the Finnish case study on the Kotitori Integrator of Home Care Services and is part of the OECD Project on Information and Communication Technologies (ICTs) for a Silver Economy. This case study will serve as a basis for discussion at the OECD Workshop on "Anticipating the Special Needs of the 21st Century Silver Economy: Smart Technologies and Silver Innovation" that will be be held in Tokyo on 12-13 September 2012.

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The working party is invited to comment on all the case studies by the end of June so that the comments can be integrated into a revised document for the workshop in September.

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INTRODUCTION

1. The aim of this report is to describe the integrator model and the integrator called Kotitori in Tampere. First, we describe the social care system in Finland and Kotitori in a nutshell. Second, we shed light on different perspectives of Kotitori and how it differs from the traditional way to provide home care services in Finland. In the last section we discuss the strengths and weaknesses of the integrator model.

2. Finland is a country with 336 municipalities (in 2012), which are responsible for organizing – funding, providing and commissioning - health care and social services for their citizens. The responsibility of the municipalities to organize social services for their citizens is defined in the Social Welfare Act launched in 1982. According to the Act, social services contain several activities such as social work, home care services, housing services, institutional care and family care. Focusing on the Kotitori the most relevant services mentioned are home care services. Home services "are provided when clients experience difficulties to cope with routine tasks at home due to illness or reduced functional capacity" (Ministry of Social Affairs and Health 2012).

3. Social care for the elderly has gone through several reforms during the last few decades. One major change during the last ten years has been about the so called marketization of social care (see Anttonen & Häikiö 2011). From the perspective of the service user, family or even a social worker, the system has become more complex than before. Also in the process of having social care services the responsibility is quite strongly put on the user of the services or the family (Appendix figure 1). One of the challenges in the current social care system in Finland is how to support the access of vulnerable client groups such as old people to services they need and prefer (See Topo 2011, 885).

Organization of the social care in Finland

4. The municipalities provide most of the social and health care services by their own public provider units or by unit owned jointly with other municipalities. However, there is a long tradition of leaning on private, mainly non-profit NGO-based providers especially in home care for elderly citizens (see Topo 2011, 882). There is also a long tradition of relatives taking care of the elderly.

5. During the past 20 years contracting the elderly care and primary health care services out to private providers has increased. Anttonen and Häikiö (2011, 6-8) have pointed out how "care is going private". Certain changes, such as legal changes in 1980s and 1990s, have paved the way for so called marketization of social care. After the early 1980s administrative reform, municipalities have been allowed to purchase social and health care services also from private for-profit providers. Since then, the municipalities have been developing their purchasing practices and also adopting ideas and working practices from the business sector. As a model to organize the municipal services the so called purchaser-provider split emerged in the late 1990s, especially among the biggest municipalities. In addition to

contracting out and provision in house, the municipalities may also offer the citizens a service voucher to be used for buying services from private providers. Vouchers are still rather marginal alternative but they are expected to become more significant part of the public care service regime.

6. The social care market has become more consolidated and, in contrast of traditional NGO-based non-profit providers, for-profit oriented one. All in all, the proportion of private for-profit enterprises has increased in social care. During the last years, private providers have produced about one third of the social care services. The most common field of private providers in social care in 2010 was housing services for the elderly. Within these services, the third sector is still an important resource for the municipalities as to the care for the elderly (see THL 2011a; THL 2011b). Usually the providers in social care have been small and local instead of large and national or international providers. Social services purchased by the citizens themselves have traditionally been consumed by the elderly people with a middle or high income. Recently purchasing of private services has been supported by giving people a right to tax deduction.

Financing and steering

7. The funding of social and health care services comes from the municipal taxation, state subsidies and out of pocket payments. Local authorities have the right to levy local taxes and thus they have a certain economic independence from the central authority (Kröger 2011, 149). The role of national government in financing and steering social care service system has varied during decades. Especially after the Social Welfare Act (1982) central agencies (a National Board of Social Welfare and provincial state offices) required action plans and reports from local social welfare authorities and inspected if they were in accordance with national policy framework. This steering was significantly loosened in 1993 (Kröger 2011, 150-151). In the 2000's, there has been a slow tendency to increase national regulation, for instance, by national quality guidelines and quality inspection.

The City of Tampere

8. Tampere is a large and growing city in Finland with currently over 213 000 inhabitants (Table 1). Tampere region includes also the neighboring municipalities and the whole area has almost half a million inhabitants. Almost half of the inhabitants are in their active working age and 16.3 % of inhabitants (about 34 000) over 65 years old.

9. In the 2000s the city of Tampere underwent a series of administrative reforms, one of the most important being the reorganization of the city's administration by introducing the purchaser-provider split. Purchasing activities were organized into six core processes, one of those being "Promoting the wellbeing of the senior citizens". It was also emphasized that the services would be organized by employing multiple providers, i.e. public, private and third sector. Although, in Tampere these multiple providers have been used long before the reforms, the reforms potentially paved the way for different and innovative ways of organizing the social and health care services in Tampere.

Table 1 Information about Tampere (Tampere statistics 2011)

Tampere
• **213 217 inhabitants (in 2010)**
• **the third largest city in Finland**
• **land area 525.0 km²**
• **the largest inland centre in the Nordic countries**
• **176 km to Helsinki, the capital of Finland**
• **16.3% of inhabitants over 65 years old**
• **43.0 % of inhabitants 31-64 years old**
• **model of mayorship1**
• **purchaser-provider split in the city administration**

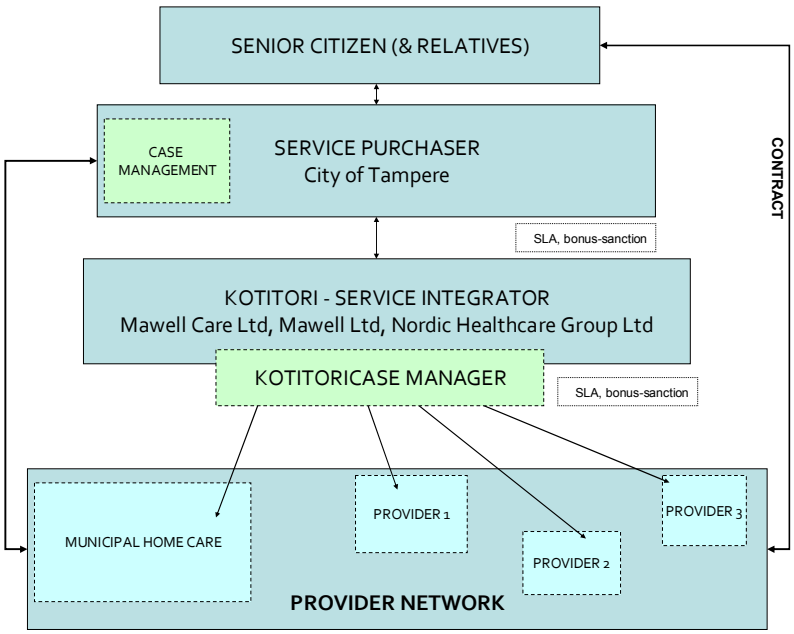
[1] The executive director of the city is a permanent professional position in other cities of Finland, in Tampere the executive director is a politician nominated for this position for 4 year period – the period between the general elections of the city council members.

INTRODUCING KOTITORI

10. In the Kotitori approach the focus is on a social innovation assisted by technological solutions. The main idea of Kotitori is to provide a "one stop shop" of home help services with easy access for the elderly and their relatives. A basic customer process is modeled in the Appedix figure 2.

11. Kotitori is operated by Mawell Care Ltd, with which the municipality has a four year contract (2009-2013) with two optional years. Mawell Care works in a partnership with Nordic Health Care Group (NHG) and Mawell Ltd. NHG is responsible for quality control and quality standards for the private providers as well as for coordinating the network of private providers. Mawell Ltd, in turn, has a responsibility for technological solutions.

Figure 1. Illustration of Kotitori model (City of Tampere)



12. Kotitori integrates services provided by the public, private and third sector providers through case management. The case managers are employed by Kotitori and most of them have either a degree in nursing or in social services. The case managers collect and put together the service packages needed by the customers. Customer may purchase the services themselves or, if the eligibility criteria are met, have the home care services paid by city of Tampere. Thus, in practice, Kotitori provides two kinds of services: *integrator services for all the senior citizens in Tampere* and *municipal home care services for the central area of Tampere* (Table 2).

13. **Integrator services include e.g.** counseling and case management; needs assessment; service and care plans for the citizens; direction the elderly citizens to private home help services provided by private providers. These services are funded by the municipality. Eligible for the services are all the senior

citizens living in Tampere or relatives who have an elderly relative living in Tampere. In addition, Mawell Care has an obligation to participate in the development of the processes and productivity of the own home care provision of the city.

14. **Municipal home care services** refer to need tested services the municipality has to organise if a person meets a certain eligibility criterion. The services are financed partly by the city and partly by the customers via user fees. These services include nursing and home care support services such as security, transport, shopping, cleaning and catering services. Tampere has outsourced the provision of the home care services of central Tampere (400 customers) to Kotitori. Kotitori purchases these services from its subcontractors. The services are financed by the municipality, but include also co-payments the level of which depends on the income level and other property of an elderly person. Mawell has subcontracted these services to private providers.

Table 2 The services organised via Kotitori, their target groups, financiers and providers

Integrator services	**For whom?**	**Financed by**	**Provided by**
Needs assessment and advice	All the senior citizens living in Tampere	The city of Tampere	Kotitori case managers
Service planning for the senior citizens	All the senior citizens living in Tampere	The city of Tampere	Kotitori case managers
Home care services and support services e.g. cleaning, shopping, security, social activities, catering etc.	All the senior citizens living in Tampere	The customers themselves	Private providers in the provider network of Kotitori
Municipal home care services	**For whom?**	**Financed by**	**Provided by**
Home care belonging to the responsibility of the city and provided by the legislation	The senior citizens who live in the responsibility area[2] of Kotitori and are eligible for publicly financed home care	The city of Tampere and user fees	Kotitori contractors Mediverkko & Palvelutähti
Support services: Security services Cleaning Temporary home care Shopping	The senior citizens in Tampere who are eligible for the services paid by the municipality	The city of Tampere and user fees	Kotitori contractors

15. Kotitori can be reached and contacted in three alternative ways: walk-in office in the city center, call center and via internet. Kotitori case managers make also home visits if an elderly person is enable to visit the office or call. An example of the customer flow during a month is presented in Table 3.

[2] Publicly funded home care services are divided in x responsibility areas of the city of Tampere. One of these areas is outsourced to Kotitori.

Table 3 The customer flow in Kotitori in December 2011

Contacts	**Number of contacts**	**% of all contacts**
Via phone	629	68
At the office	232	25
Home visit	66	7
Total	927	100
Services provided via Kotitori	**Number of new customers**	**% of new customers**
Municipal home care services	16	27
Private home care	14	24
Private support services	29	49
Total	59	100

16. Private providers can apply for Kotitori provider status via Kotitori website. A list of all the registered and approved providers, their contact details and descriptions of service packages are available in the Kotitori website. In addition to this standard provider status, a provider can choose to become *a Kotitori partner provider*. Kotitori partnership means that the providers are obliged to comply with service standards and prices defined by Kotitori. Partnership status is subject to a charge paid on annual basis. The charge is dependent on the annual revenue of the provider[3]. For the annual charge, the partners are eligible for using Kotitori brand in their advertising. Moreover, the services of partnership providers are actively marketed to the customers by the Kotitori case managers. In 2011 Kotitori had altogether 102 providers of which 28 were partner providers.

[3] Annual revenue

- less than 150 000 € : charge 200 € / year + vat

-150 000 - 500 000 € : 350 € / year + vat
- 500 000 - 1 000 000 € : 500 € / year + vat

- over 1 000 000 € : 1 000 € / year + vat

A SHORT HISTORY

Sowing the seeds

17. The seeds of Kotitori were sowed at a national level working-group that was established to consider new ways to organise the services for the growing elderly population in the early 2000s. The working-group was established by consulting company Eera. It received the assignment from the Ministry of Treasury, which had an interest to economise health care service structures in Finland and, thus, look for new innovative ways to organise health care services in the country.

18. The working-group involved representatives from the municipalities of Tampere, Espoo, Turku and Oulu, all among the ten largest cities in Finland. The member cities of the working group were provided with an opportunity to start developing the service delivery structures in the area they considered important in their own city. Tampere decided to embark on the development of new models of services in the area of *home care for the elderly*.

Creating and developing a service innovation

19. The development process was initiated in the spring 2005 by putting a task force in place. The process was led by the senior physician of the elderly care services in Tampere. The process was conducted in co-operation with Pirkanmaa hospital district, consulting company Eera, Technical Research Centre of Finland (VTT), telecommunication firm TeliaSonera and IT-consulting company WM-data (currently Logica). The process resulted in an idea of a service integrator that would combine the counselling on and coordination of public services and private services purchased by the citizens themselves.

20. In order to pilot the new model of service delivery and to further develop it the city of Tampere applied funding from the Finnish Funding Agency for Technology and Innovation (Tekes). Tekes had launched a programme (Finwell) that would award funding for *local level projects* aiming at developing innovative solutions for health care and social services. The application was successful the funding was awarded for the pilot project which was called *"New models of cooperation – their evaluation and development in home care services for the elderly people"*. The name of the project referred to the aim of the project which was to develop a service delivery model with novel forms of co-operation between public and private sector.

21. This pilot project was initiated in 2006 in Tampere. Administratively the project was established under the office of the deputy mayor responsible for the health care and social services in the city of Tampere and the director of the project was the current service-purchasing director of the elderly care services. The main aim of the pilot project was to develop the actual Kotitori concept. This was done by analysing the contemporary state of the own home care provision of the city, defining the targets for the development of the service provision, modelling the principles and practices of the service purchasing, developing the actual integrator model, investigating juridical issues potentially related to the integrator model and exploring the alternatives for the integrator model. The development phase resulted in three optional ways the integrator model could have been implemented:

1. City operating as an integrator-This model would have not altered the contemporary situation to any large extent. The city would still have an obligation to organise procurement in order to purchase services from private sector[4].

2. Joint-organisation involving the city and private partners-The city would have coordinated the operations of the joint-organisation via contracts. However, as the city would be involved the joint organisation would have been defined as a public purchasing unit. Hence, it would have an obligation to organise procurement in order to purchase services from private sector.

3. A private consortium operating as a contractor of the city -This would have been a novel model of Public-Private Partnership, which was expected to create new models of service business and innovations. As the private consortium would be a contractor of the city it would not have an obligation to organise procurement in order to purchase services from private sector.

22. Of these models the latter was chosen as the model the city started to develop further and implement, because it was considered being the most appropriate solution to answer the need of the city. One of the main arguments was that as the integrator would be an actor operating outside the city organisation it would have been able to operate in a more flexible way. By flexibility it was especially referred to the demanding procurement processes that were obligatory for public units.

23. While the new model of service delivery was sketched, the pilot project was coming to its end. Consequently, continuation for funding was applied and awarded from Tekes's *Finwell-project*. The development of Kotitori reached a new phase, the phase of implementation.

Implementation

24. Implementation project called Kotitori-project was initiated in the spring 2007. It aimed at the implementation of the integrator model and was based on the development work done during the pilot project described above. The main aim was to implement the integrator model in which a private provider would operate as the service integrator, which in turn, would be a contractor of the city.

25. During the project the city conducted a Request for Information –survey targeted to private service providers and to the third sector in order to explore the providers' willingness and ability to operate as the service integrator. Also the technological preconditions were investigated and the business plan for Kotitori was developed.

26. The introduction of a new model raised opposition among the politicians in the City Council[5]. The representatives of the city of Tampere described that it was especially the conservative representatives in the city council that had reservations towards Kotitori model. More liberal representatives were, in turn, rather positive towards the new model of service delivery. Due to the controversies in the City Council, the City Board[6] moved Kotitori project under the direction of the Mayor's office. Thus, the implementation phase was conducted at the highest possible level in the city administration. All the political decisions were

4 The competition law provides municipalities to apply competitive tendering to all the public purchases exceeding xx 000 Euros

5 The supreme decision-making body in the City of Tampere with 67 members. Council members and their deputies are elected in a municipal election held every four years.

6 The City Board has a chairman and 10 other members who each have a personal deputy. The City Board administers the municipality and manages its finances, prepares and implements the decisions made by the City Council and ensures that they comply with the current legislation.

made by the city board. The proposal for the integrator model was passed in the city board in 2008 and the preparations for the bidding process through which the integrator would be selected were started.

27. The bidding process was executed trough *consultation process*. At the first stage the city invited providers to informal meetings and workshops in which the city introduced the idea about the integrator model. After that the providers were invited to introduce their own ideas on the implementation of the model. Based on the workshops and the proposals of the providers the city prepared the tender and started with the bidding process in 2008. In the bid the services the integrator would be responsible for were defined as follows:

1. Integrator services

- Counselling on private service options available for the elderly
- Case management (i.e. integrating public and private services)
- Needs assessment, service plans and care plans for the elderly
- Developing the processes and productivity of the own home care provision of the city

2. Municipal home care services

- Provision of municipal home care in the central area of the city
- Catering
- Security
- Temporary home care
- Cleaning
- Shopping

28. In the bid it was emphasised that the provider of the integrator services would not be allowed to provide the home help services described above. Instead, it was provided that the integrator has to contract those services out to its subcontractors. The contract was supposed to be signed for four years. In addition, two optional years were included in the contract.

29. At the first phase five bidders left their bids. However, three of the bidders did not fulfil the qualifications set for the providers. Two of the bidders were too small and one of them did not fulfil the requirement that the integrator should not be the service provider it self. Thus, there were two provider consortiums[7] with which the city eventually started the negotiations.

30. The negotiation process was described to be crucial for the development of the final Kotitori concept. It was described by the service-purchasing director, who attended the negotiations that *"the model would not have been as it is if wasn't for the negotiation process. We would not been able to create anything like this by ourselves"*. In addition she described that because the negotiation process was relatively long and demanding involving several intense negotiations, the relationship between the parties

[7] Mawell Care and Nordic Health Care Group

became tight and involved the establishment of mutual trust between the parties. The bidding process was closed in 2008 and the contract was awarded for the consortium led by *Mawell Care, the current provider of the integrator services.*

THE IMPORTANT NEEDS AND THE INNOVATIVE SOLUTIONS TO ANSWER THEM

Integrator services

Demographic changes and predicted increase in the demand for private services – a need for a service integrator

31. In the city demographics there have been several developments due to which it was seen necessary to support also the private consumption of home help services. Firstly, the city of Tampere was concerned on the population ageing which would potentially result in growing demand of the services. According to the prediction by The Statistics Finland the population aged 65 and over would increase in Tampere from 33 000 in 2008 to almost 60 000 by the year 2040 (Figure 2). Especially substantial the growth was predicted being among those aged 85 and over. In that group the growth was predicted being from 4000 in 2008 to 15 000 by the year 2040. In this group also the coverage of regular municipal home care has increased most rapidly since the early 2000s (Figure 3). It was perceived that while the city is not able to answer the growing need of the services in the future. It was estimated that the eligibility criterion for home care funded by the municipality has to be tightened in the future, e.g. due to the growing demographic dependency rate (Figure 4) resulting in fewer taxpayers in relation to the elderly and children.

Figure 2. Predicted population growth in 65-74, 75-84 & 85-94 year olds in Tampere by 2040 (Statistics Finland)

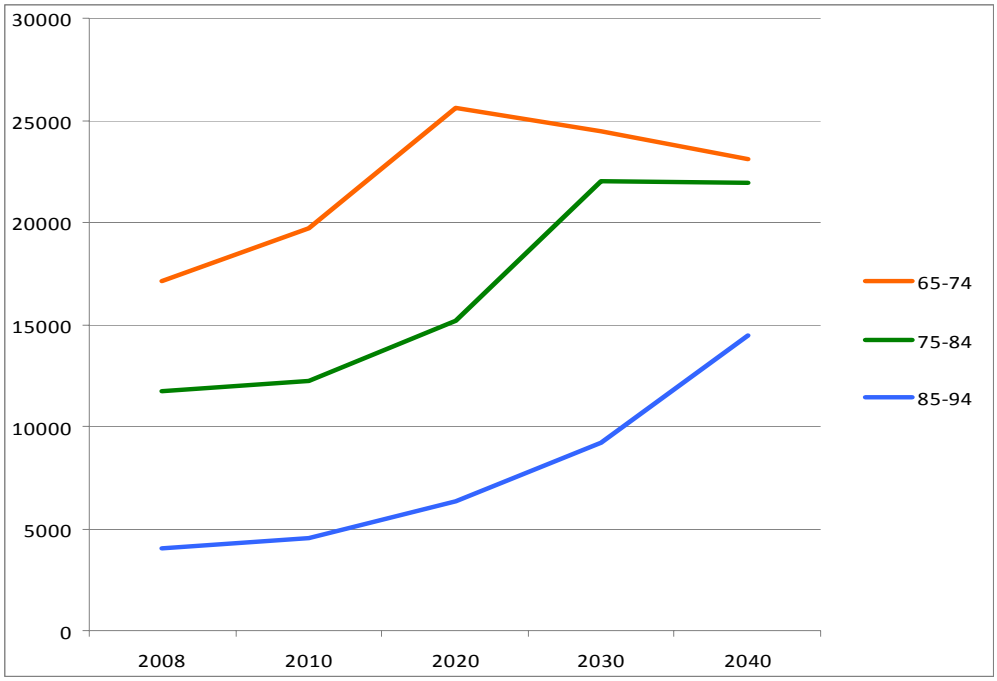


Figure 3. The proportions of regular home care clients as % population of the same age in Tampere in 2001-2010 (SOTKAnet)

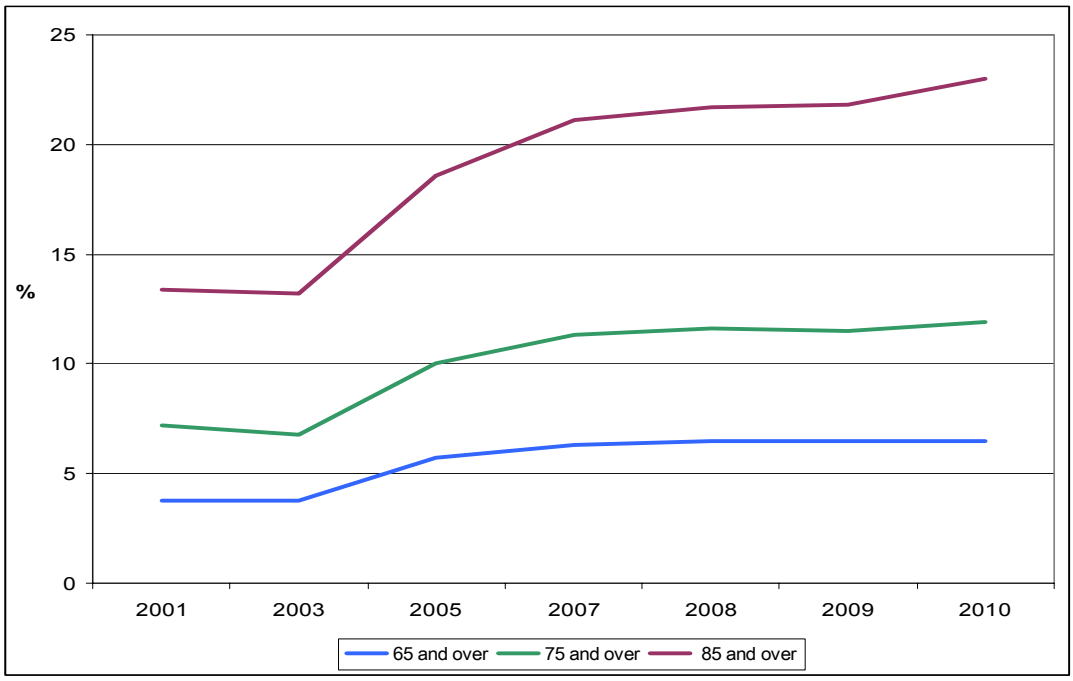
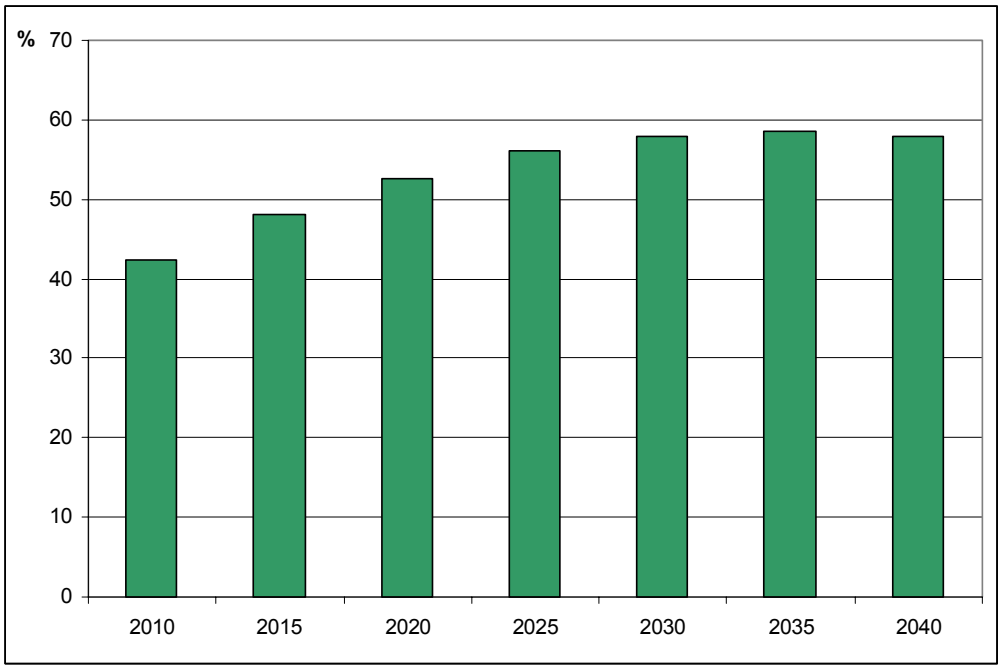
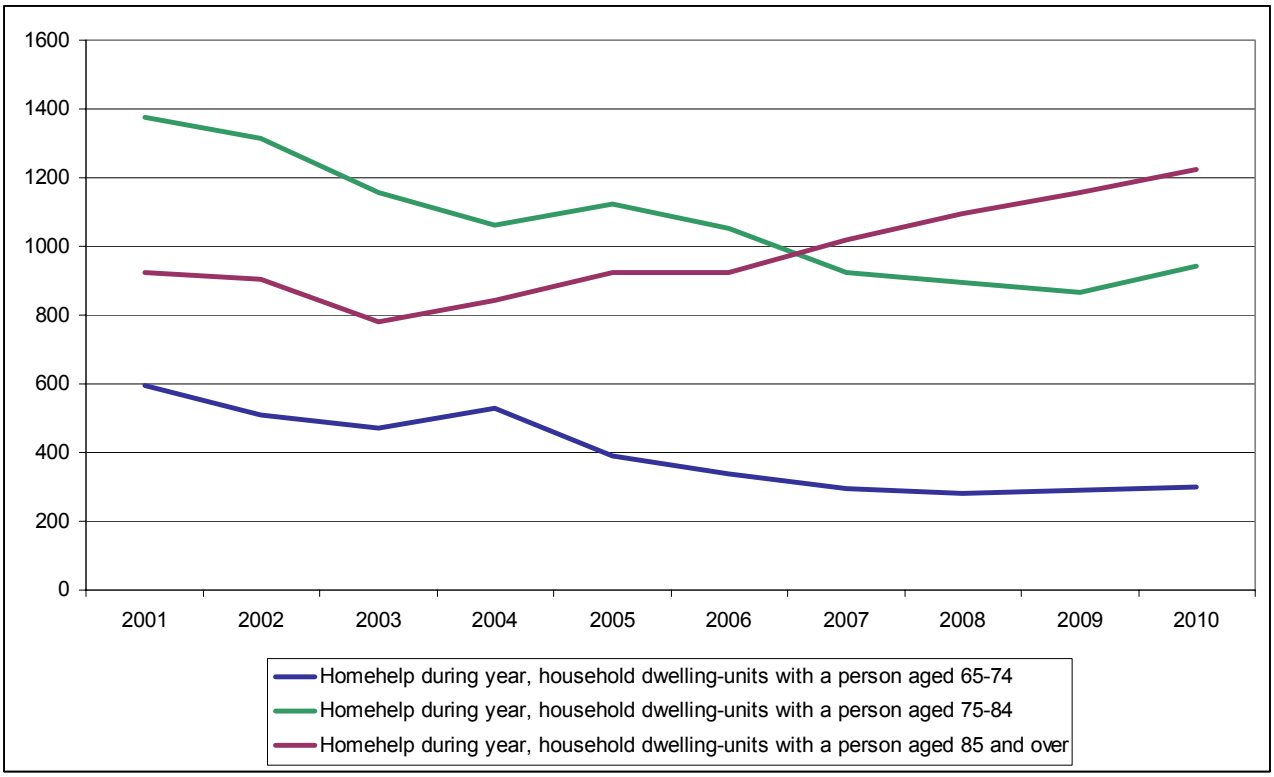


Figure 4. Demographic dependency ratio: the number of children (0-14) and the elderly (65+) in relation to 100 15-64 year olds (Statistics Finland)



32. Secondly, while the coverage of the home care services, especially among those aged 65-84, has remained rather constant during the past decade (Figure 2) the absolute number of those not receiving municipal home care has increased and potentially will increase also in the future due to the tightening eligibility criteria for municipal home care. In addition, the number of households receiving home help services organised by the municipality has decreased especially among the 75-84 year olds (Figure 5). By introducing the integrator model the city wanted to guarantee that the services are available for the citizens even thought not paid by the public sector.

Figure 5. Household dwelling-units that received home care support services organised by the municipality during a year, 2001-2010



33. Thirdly, approximately 50 %of the 75 year olds and older citizens in Tampere live alone. While the majority of those receive help from their relatives, there are also a growing proportion of those elderly citizens who do not (ref.). For them private home help services were seen as complementary to the informal care provided by the relatives and thus, it was seen important to make the access to private services easier.

34. In addition to the predicted need for private home help services it was estimated that the elderly have also increasing potential to pay for the private service. For instance, the proportion of those receiving only the smallest possible pension (full national pension[8]) has decreased steadily during the 2000s (Figure 4). Moreover, since 2001 the households have been eligible for tax deduction for household services such as home repair, care for the elderly or children, cleaning, catering and shopping. The use of tax reduction for household services has increased steadily among the pensioners (i.e. those aged 65 and over) since

[8] Those receiving only the full national-pension are mostly eligible for also other benefits such as housing benefit.

2001 (Figure 7) indicating also a growth in the consumption of private services. However, the income differences among the elderly have increased (ref.) and tax deductions benefit only the elderly in the highest income groups.

Figure 6. Those aged 65 and over receiving only full national pension in Tampere and in the whole country in 2000-2010, as % of population of same age (Statistics Finland)

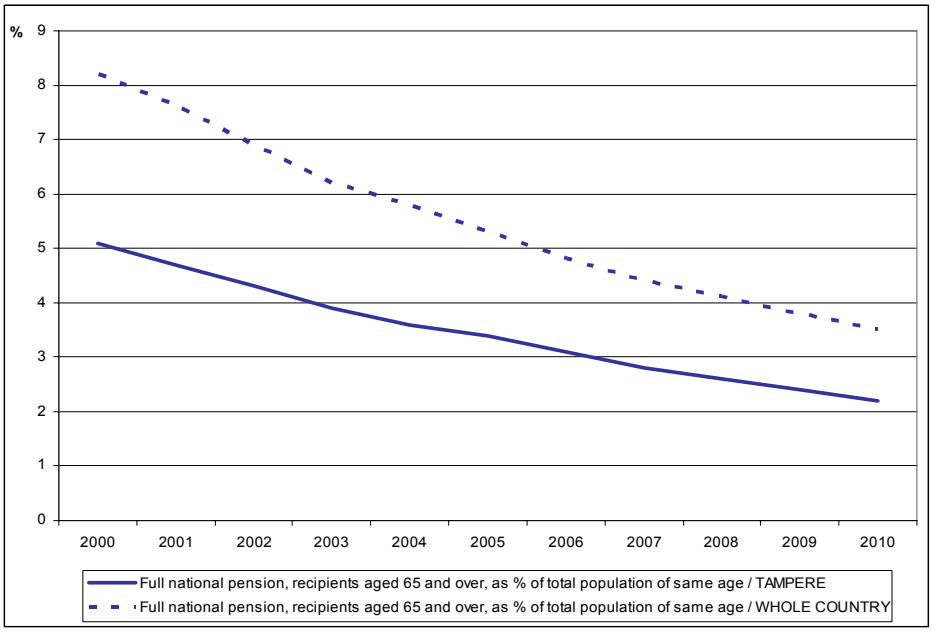
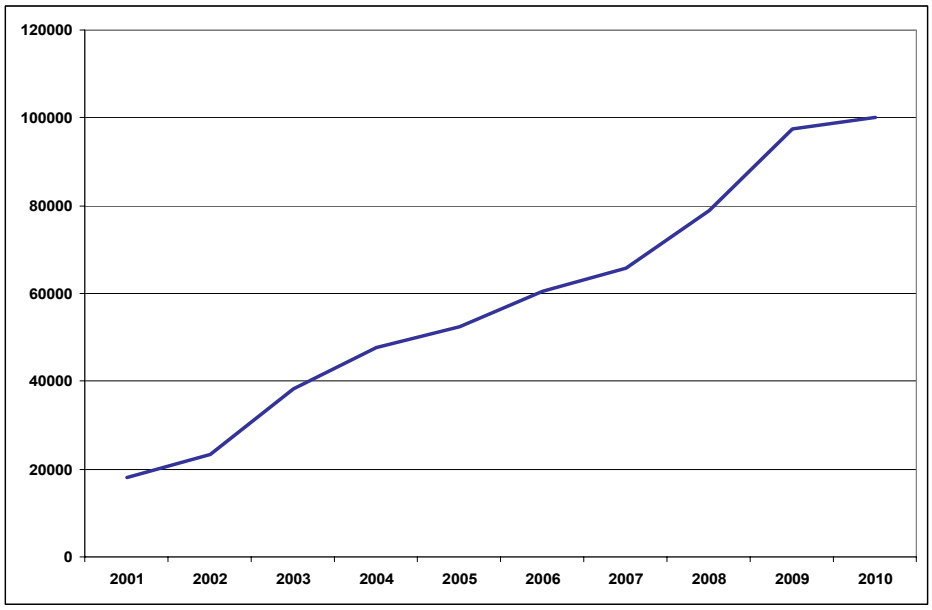


Figure 7. The number of pensioner households using tax deduction for household services in Finland in 2001-2010 (Taxpayers' Association of Finland)



Clarifying complicated provider market

35. In order to support the consumption of the private home help services it was seen necessary to clarify the provider market that had become diverse and complicated from the customers' point of view. By diverse and complicated it was referred to the lack of aggregated information of the service providers operating in the field of home help services. It was described by the city that while the elderly might be able to consume the private services they may not be aware of all the services that would be available for them to purchase. In other words, complicated and scattered private service market was perceived impeding the consumption of private services in the situations an elderly person would benefit from them.

36. One aim behind Kotitori model was to establish broker organisation, i.e. the integrator, to operate between the customers and the private providers and to collect a network of private providers that would have a potential to make the use of private services easier for the citizens who can afford it. The integrator is responsible for running a provider network which consists of providers from different service fields. With this network Kotitori is able to provide a "One stop shop" with easy access for the elderly and their relatives. Kotitori case managers work as key actors in integrating the services provided by different providers from different sectors. The customers can get information about the services provided via Kotitori and contract Kotitori case managers by visiting the Kotitori office at the city hall or by calling to the Kotitori call centre. An information package, including the list of providers, services, quality standards etc., is available in Kotitori's Internet portal.

From standard packages of care towards diverse service solutions

37. In addition to demographic changes, there was also a cultural change among the elderly care professionals, among the elderly themselves and in the society that pushed for the new models of service deliver. Kotitori model was needed as it was finally acknowledged that the needs of the elderly population were diverse and that they had to be met with diverse means. It was seen that combining private, third sector and public services would potentially result in more versatile selection of services for the elderly and their relatives.

38. Kotitori case managers use *solution-focused approach* to meet the needs of the elderly customers. This approach was initially adopted from the child protection services in which the service manager of Kotitori had previously worked in the city of Tampere. The main idea of the solution-focused approach is that the services are tailored on the basis of the customers' needs, hopes and preferences. Thus, the customer is not provided with a standard package of services, but with tailored help that enables the customer to lead a life she/he is accustomed to and which is in accordance with their wishes. This is done, by selecting the appropriate mix of the public, private and third sector service providers. The help may also actualize in the form of social activities or hobbies.

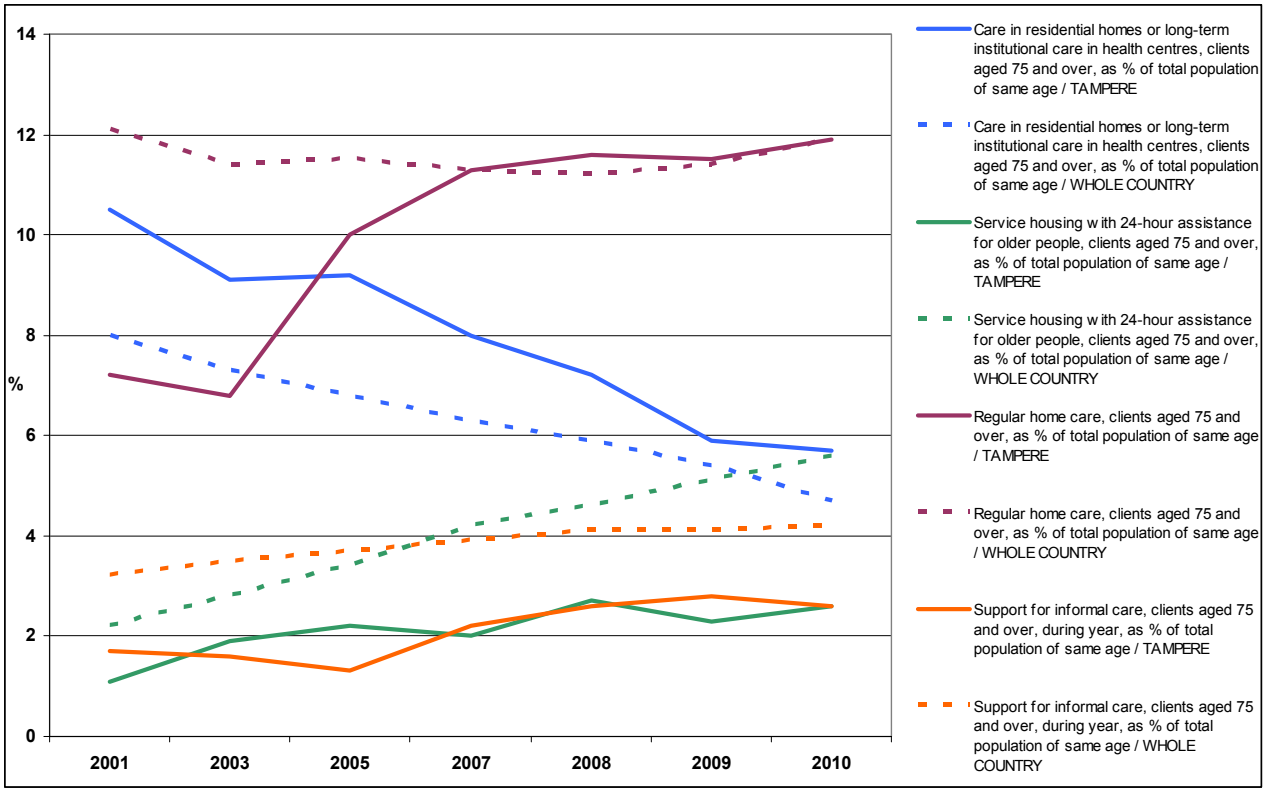
Municipal home care services

Policy shift – need to develop the own home care provision of the city

39. A relatively large proportion of the elderly receiving institutional care has been distinctive to the service delivery structures in Tampere (Figure 6). However, during the last two decades the emphasis of national level policies has shifted from institutional care towards home care and home help. This potentially worked as an incentive also for Tampere to embark on developing its home care services. Changing the service structure towards out-patient oriented service provision was seen essential also because if nothing was done the increase in costs would be uncontrollable in the future, the institutional care being substantially more expensive compared to outpatient care.

40. The city perceived that the service culture in its own home care unit was not customer oriented, efficient or productive. It was acknowledged that the delivery patterns and working culture needed to be changed systematically. However, despite of several attempts by several managers at different levels of the organisations the development had not been successful. Consequently, the city decided to proceed the work with the help of an actor coming outside the city organisation. Thus, in Kotitori contract it was agreed that the service integrator contributes also to the development of the city's own home care provision. In addition also the private providers delivering the municipal home care have tried actively to communicate their ideas to the representatives of the city. The development work has especially focused on the information architecture of the city.

Figure 8. Service delivery structures in Tampere and in the whole country in 2001-2010, as % of the total population of same age



Streamlining the procurement process

41. The competition law (Laki julkisista hankinnoista 2007/348) provides municipalities to apply competitive tendering to all the public purchases exceeding 100 000 Euros. If a public procurement is executed there are two alternative ways to proceed as to a traditional model of organising services:

1. Organise a procurement fot the whole service package and contract with one provider

- Bidding for the services of a large area or for a big service package enables only a few large provider organisations attend

- Small providers may be competed out of the market
- The costs of the process would be relative moderate

2. Divide the area in several subareas and contract those out to small providers.

- The costs of contracting would substantially increase due to several negotiations with several small providers.
- Would enable also smaller providers to attend.

42. The city wanted to streamline these demanding procurement processes in home care services belonging to its responsibility. At the same time it was also perceived important to support the local providers and local employment. However, it was seen that this was not easy in the traditional service provision model applied in the public sector. Thus, as a part of Kotitori model the city of Tampere decided to contract out the municipal home care services of one area of the city (i.e. the central area). The services were contracted out to the provider of the integrator services (i.e. Mawell Care), which was obliged to subcontract the services out.

43. This approach enables the municipality to harness the advantages of both alternatives. As to the municipal home care services of the central Tampere, Kotitori model provides a single bidding process from the municipality (that is the procurement of Kotitori) but enables the municipality to indirectly support also small providers as the integrator is allowed to sub-contract with several small providers.

Table 4 A summary of the perceived needs, problems in a current situation and solutions provided by Kotitori

Integrator services			
Driver behind the needs	**Need for new policies**	**Problem in the current situation**	**Solution provided by Kotitori**
Population ageing	Growing demand of services	Inadequate resources of the municipality → tightened eligibility criteria for municipal home care services	- Support for private consumption of home care and home help services
Inadequate resources of the municipality	Support for private consumption of home care and home help services	Diffuse service network. People are not aware what services are available for them to consume privately.	"A one stop shop" in which the information of the services provided by the public, private and the third sector are gathered in a one place.
Cultural change	Diverse service needs of the elderly population	Rigid/standard packages of care provided by public sector	Tailoring services for the citizens applying case management and combining the services provided by the public, private and third sector.
Municipal home care services			
Driver behind the needs	**Need for new policies**	**Problem in the current situation**	**Solution provided by Kotitori**
Increasing contracting out of municipal services	Streamlining the bidding process but also support small, local providers	The bidding process would be very demanding and costly if the city had to negotiate with all the small providers separately	Contracting with an integrator that is allowed to make contracts with several small providers
Shift in the policy: emphasis from institutional care to home care	Develop the own home care provider organisation of the city	Rigid and conservative working culture in which the implementation of changes have perceived difficult, if not impossible	Including consultation and development tasks in the contract with the integrator

THE CONTEXT IN WHICH INNOVATION IS TAKING PLACE AND THE ENABLING CONDITIONS?

Demographic changes

44. Demographic changes were the main driver, as the very first discussions on integrator model were started first at the national level and then locally in Tampere. It was forecasted that the demand for the elderly care services is potentially increasing while the resources were rather decreasing or staying constant (see above).

Characteristics of the city and Reforms in the city organisation in 2000s

45. In order to be appropriate, Kotitori approach requires a large enough population base. Tampere is a relatively large city with c. 200 000 inhabitants and thus provides a population base large enough for a service market in which multiple providers may operate and even compete. The context is also urban, which lets one to assume that there is slightly more purchasing power in the population compared to the more rural areas. Moreover, Tampere has a strong tradition of exploiting private, mostly not-for-profit organisations, in their service delivery, especially in field of elderly care.

46. In 2000s city of Tampere went through a series of administrative reforms. As to establishment of Kotitori, the most important reform was the one of the city administration that was reorganised by introducing purchaser-provider split. Purchasing activities were organised into six core processes, one of those being "Promoting the wellbeing of senior citizens". It was also emphasized that the services are organized by employing multiple providers, i.e. public, private and third sector. These reforms potentially paved the way also for Kotitori establishment by opening the widow of opportunity for further reforms in the organization of the services.

Market conditions

47. The local providers market was going through two parallel reform processes during the late 1990s and the early 2000s. On one hand there was an increase in the number of small private providers and it was felt in the city that the service network was becoming diffuse, which is why it was perceived that that it was rather difficult for the citizens to benefit from. On the side of the elderly care services contracted out to private sector the market seemed to be developing towards an oligopoly in elderly care services. There were nationally a few big provider organisations[9] that, if nothing was done, were feared to take over the market as the small providers had rather poor changes to succeed in the competition with the big firms. These two parallel developments pushed the city to search for alternatives that would support the establishment of a more coherent service network and that would improve the conditions of the small local providers to participate in the service delivery.

Policy entrepreneurs, political mood and drive for innovations

48. In order to arise, an innovation needs actors to promote it. As to Kotitori one can identify several policy entrepreneurs that saw its potential and started to promote the idea. Firstly there was a person who took the idea from national level working-group to the city level. Then there was the director of

[9] Mostly owned by multinational private equity companies. Several provide both health care and the care for the elderly (especially sheltered housing)

development of wellbeing services. Finally there was the mayor who supported the idea even though it did not pass the city council at the first place.

49. In addition, to the active individuals in the city administration a supportive political mood is a crucial to the new innovations to be materialized. In 2000s and even before there has been a strong will to search new ways to find novel ways to organise municipal services. This strong drive for renewal of the service delivery patterns and the administration of the city has most potentially contributed also to the establishment of Kotitori, which really was (and still is) something quite unique in the Finnish context.

National level supporters for the local initiative

50. In addition its local supporters, Kotitori had also national level supporters that contributed to its establishment. These included the Finnish Funding Agency for Technology and Innovation (Tekes), which provided funding for the pilot project of Kotitori, Ministry of Employment and the Economy, and Nordic Healthcare Group, which is a private think thank and a part of the Kotitori consortium.

Consultation procedure

51. The negotiation process was crucial for the development of Kotitori for at least two reasons. Firstly: "The model would not have been as it is, there would not have been the negotiation process. We would not been able to create anything like this by ourselves." the purchasing director described the importance of the negotiation process through which the actual model was created in cooperation with the city and the private contractor. Secondly, it was described that as the negotiation process was rather long and demanding, the relationship between the parties became tight and involved mutual trust between the parties.

52. The integrator described the consultation process rather costly and demanding. One reason for that was that while it negotiated on a contract with the city it had to organise its own procurement on the home care services that it would be responsible for. It was also described that even though the procedure was called negotiation/consultation procedure it lacked the dialogue between the bidders and the city. That is, the city must be neutral and give the same information for all the bidders. From the providers point of view it might have been better if the process had based more on informal negotiations.

Adequate technological solutions

53. In order to work efficiently Kotitori approach provides appropriate technology. Mawell Ltd has experience in similar technological solutions in a number of other service fields.

Legislation and national level policy

54. Legislation provides municipalities to apply competitive tendering to all the public purchases exceeding xx 000 Euros. Contracting with several providers is rather costly, which may put municipalities to search for alternatives that would reduce the costs of public procurement. Moreover, during the last two decades the emphasis of national level policies has shifted from institutional care towards home care and home help. This potentially worked as an incentive also for Tampere to develop its home care services. Changing the service structure towards out-patient oriented service provision was seen essential also because if nothing was done the cost increase would be uncontrollable in the future.

THE SPECIFIC BENEFITS – ARE THEY SUPERIOR TO TRADITIONAL ALTERNATIVES?

55. Kotitori has been operating for three years and thus, is in its early steps. While we are not able to provide any hard data on the implications of Kotitori model we can contemplate the model's potential pros and cons from the perspectives of different stakeholders.

Customer perspective

Integrator services

56. From Customers point of view the major difference between Kotitori model and traditional model to deliver services relates to the availability of private services (Table). In the more traditional system there has not been any formal integration of public and private services, while one of the Kottori's main tasks is to deliver private services for the citizens. Thus, it seems that the benefits of Kotitori model are two-fold. The customers who can afford to buy private services do potentially benefit from Kotitori model. In turn, for the citizens not able to purchase the private services Kotitori may not bring added value compared to the traditional model of service delivery.

57. One aim of the Kotitori model was to clarify the service network for the elderly and in that way support the use of private home care services. Kotitori model has potentially made it easier for the elderly and their relatives to seek private services and purchase them. In this sense, the citizens may be exercising bigger choice compared to the more traditional system. In addition, the choice may also be more informed than in the situation the elderly purchase the services from the private sector without the support of case managers, who help the elderly customers to make their choices on private services. Thus, the integrator model may be especially beneficial for those elderly citizens who can afford private services but do not have relatives who potentially would help in the decision making.

58. The contract between the city and the integrator is base on a Service Level Agreement (SLA) in which the minimum level of the quality of the services is defined. As to integrator services the agreement is signed by the city and the integrator. However, the same service levels apply to all the private providers the integrator approves to its provider network. Because of this the representatives of the citizens found integrator model more secure way for the elderly to purchase the services compared to a more traditional situation in which the citizens consume private services without quality control of any third party. As the integrator is connected with the city, which provides the integrator to comply with a certain level of service quality the integrator is obliged to regularly monitor the providers in its network.

59. Kotitori is marketed as a "One stop shop" of the home care services, referring to a market place in which the elderly are provided with information on private services. For the elderly who cannot afford private services Kotitori does not, in its current form, provide added value compared to the traditional system. "One stop shop" does not involve primary and secondary health care services or the service from other sectors of the city. The model might benefit all the citizens better if, in additional to municipal home care services and private services, the elderly were also able to have an access to health care services via Kotitori. Currently the co-operation with health care services was described to be difficult by the Kotitori case managers. It was especially emphasised that the health care professionals do not seem to be aware of

Kotitori and it services. From the customers perspective this is an important point that should be taken into account if a similar service concept is developed elsewhere.

60. Currently e-Kotitori seems to be in a minor role as to the operations of Kotitori. Kotitori case managers describes that the users of e-Kotitori are mainly the relatives of an elderly person. It is rather expected as the number of the elderly actively using internet is rather low compared to other age groups. However, in the future the importance if e-Kotitori may increase as the coming generations are used to the web-environment. However, the care for the elderly is a service that can never be taken wholly to the internet as the ability of the use these services may be substantially lowered if a person's ability to survive without services is low. Thus, also role of the relatives in using this service will potentially remain large.

61. Finally, the Kotitori model acknowledges that the senior citizens are not a homogenous group, but a group with diverse needs, abilities and desires. In the very core of the Kotitori model are the case managers, who use *a solution-focused approach* in their work. That is the point of the departure is not a standard service package, but the customer needs and wishes to which the solutions are then adapted. In addition, it was emphasised by the case managers that in Kotitori approach it is possible to combine several kinds of services but also other activities, such as social activities and hobbies, for the senior citizens.

62. The solution focused approach can be regarded quite different from the traditional model of the municipal home care services in which the customer need are adapted to standard service packages and not vice versa. Naturally, the working culture could and should be developed in this direction also in public sector. For Mawell it was, however, potentially easier because it started from the zero without a burden of the history of the management traditions in the city. Thus, compared to the employees in public sector, the Kotitori employees and management were freer to innovate and find the solutions for their own work. In addition, Mawell was also bound by the contract to find more flexible and innovative ways to organise the services. Finally, the organisation of Kotitori was described being more flexible than the one of the city. The flexibility refers to the ability to change the processes and working patterns if a need for change was perceived. In the city organisation, in turn, the management culture was seen to support stable and unchangeable working patterns (or at least they do not encourage employees to develop them further). They also described that in comparison to the city organisation, in Kotitori the managers fully trust their employees. This was seen crucial as to the innovation and creativity among the personnel.

63. The solution focused approach and the ability to work proactively as to the customers' needs indicate that Kotitori model is, in this respect, potentially superior to the traditional model of service delivery. However, it must not be taken for granted that the private providers are the only actors that are able to change and operate proactively. Thus, to be able to create a working culture similar to Kotitori does not necessarily need an integrator model to be successful. On the other hand the solutions tailored to the customer seem to be rather dependent on the supply side of the services. If an old lady needs a hair cut but there is no hair dresser in the network it may be that the lady is left without the service. At its current form Kotitori does not seem to be a user led innovation to any large extent.

Municipal home care services

64. If we look at the customers' satisfaction in the municipal home care services it seems that there are no substantial differences between the different areas of Tampere in 2010 and in 2011. In 2010 the respondents were asked to evaluate the quality of home care on scale 4-10. The average in Kotitori area was 8 while the city average was 8+ (Figure 9). In 2011 the customers where asked to rate the quality of municipal home care services, satisfaction with municipal home care services and satisfaction with municipal home care support services on scale 1-5. In general, customers were most satisfied with support services and least satisfied with the quality of home care (Figure 10). The average in all three categories was lowest in Kotitori area, but the differences were not substantially different between the areas. In a sum,

the performance of the private providers in the Kotitori area has not been superior to the performance of the public providers as to customer satisfaction. Thus, whether the services are provided via integrator by private service providers or through a system without a service integrator does not seem to have an influence on the customers' perceptions of the services.

Figure 9. The quality of home care rated by the customers on a scale 4-10. Comparisons between Kotitori area and other areas operated by public providers in Tampere in 2010

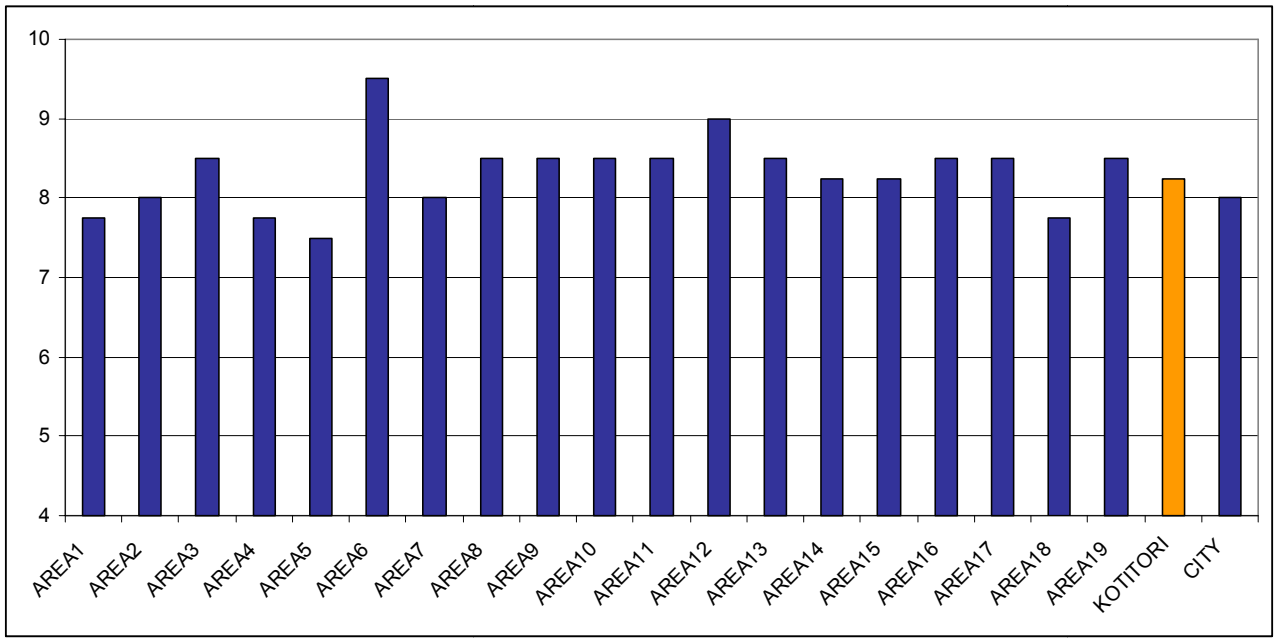
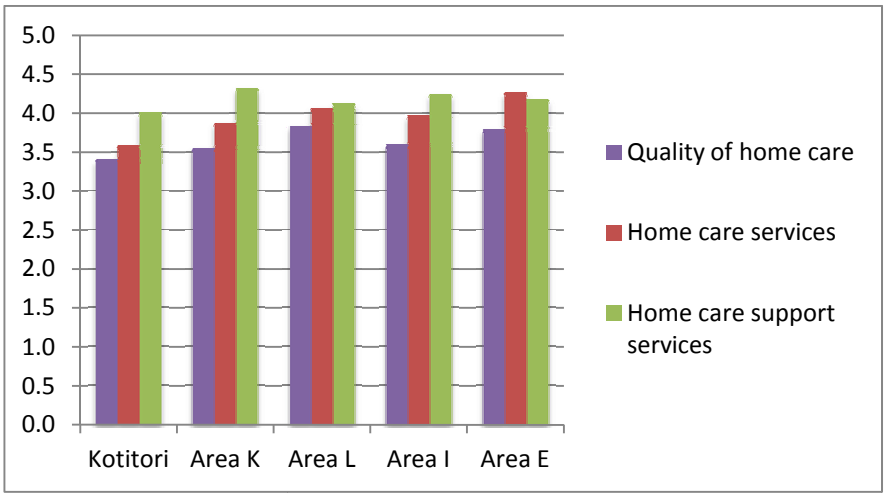


Figure 10. Customer satisfaction with home care services, home care support services, and with the quality of home care presented in service areas operated by public providers (Area K-Area E) and Kotitori area operated by private providers in 2011.



City of Tampere

Integrator services

65. The city of Tampere has potentially been one of the biggest beneficiaries of the Kotitori model. The model involves substantial agreement on consultation and development work of the own home care provision of the city. The development work includes the development of the processes and working culture at the systemic level but also development of the technological architecture of the city. Especially one of the subcontractors of Kotitori has been active in communicating its technological solutions applied in its own home care towards the city. It has participated for instance in the development of the ERP system of the city. Nordic Health Care Group, in turn, provides the city with the data on the performance[10] of Kotitori providers but also on the performance of the own providers of the city. Thus, the Kotitori model provides the city with a benchmarking opportunity and tool to develop its operations with this knowledge.

66. The integrator model in which the citizens are provided also a possibility to purchase private services creates an opportunity for the city to transfer a part of the costs of care to the citizens. The model makes it increasingly possible for the city to tighten the criteria for the municipal home care services and support services as the citizens access to private services is supported via integrator model. The idea of the city to invest in Kotitori was that, if the services were utilized timely (i.e. early enough), the use of costly A&E services, hospital wards and the rate of hospitalizations would potentially decrease. Thus, if the support for living at home is increasingly purchased also by the citizens themselves it may be that the model results in cost savings.

Municipal home care services

67. The contact on municipal home care services is based on SLA (see above). In addition it includes a bonus-sanction model, which is not common either in the contracts on health care and social services or in the contracts between purchaser and provider in the in the municipal organisations in Finland. The bonuses are rewarded if the integrator is able to meet the performance targets for home care set in the contract. If the targets are not met the integrator is sanctioned by the city. The indicators to measure the performance include e.g. transfers to sheltered housing, use of hospital wards and utilisation of A&E services, i.e. the services that are more costly for the city compared to the home care services. These incentives in the contract have potentially meant to prevent unnecessary use of hospital wards and A&E services as well as early transfers to sheltered housing or institutional care. However, they also leave us with a question, whether they can also work as barriers to receive e.g. secondary care or sheltered housing services also in cases the use of these services would be necessary.

68. The integrator monitors the performance of Kotitori home care providers based on the performance indicators set in the contract between the integrator and the city. According to the self-evaluations conducted by the integrator[11] in Kotitori area there was e.g.:

- 29 % lower rate of transfers to sheltered housing compared to other areas
- 30 % lower secondary care hospital costs compared to the costs of the elderly population in other areas
- 15 % primary care hospital costs compared to other areas

10 E.g. the performance measures indicated in the contract between Mawell and the city

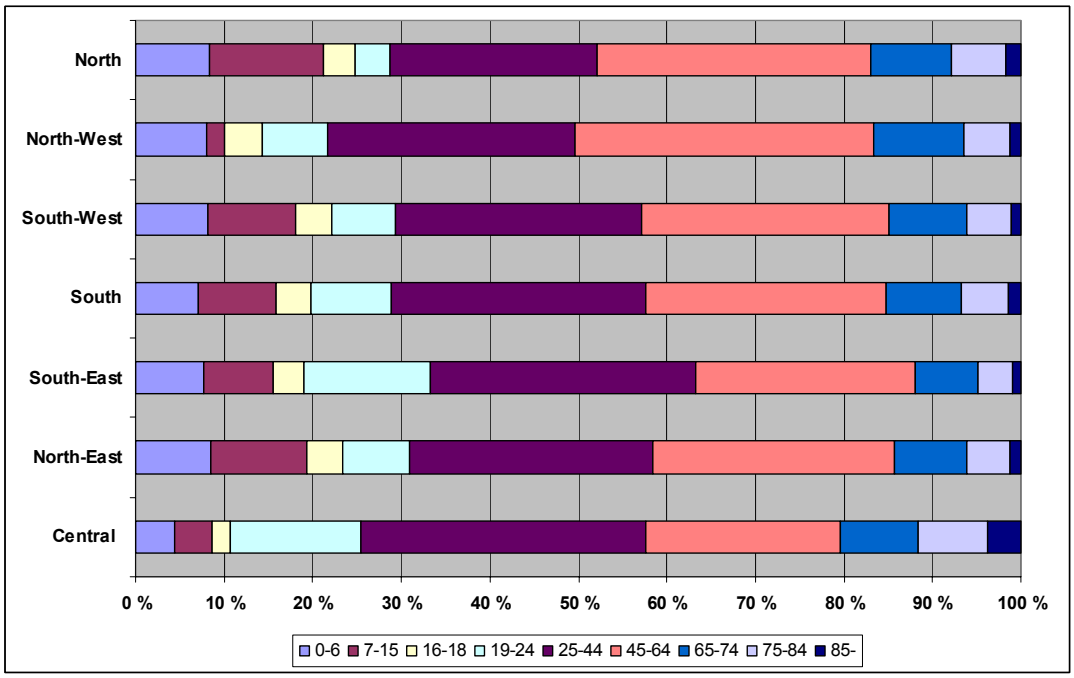
11 In particular, it is Nordic Health Care Group that conducts the evaluations and collects data on the performance of the providers

- 14 % lower utilisation of A&E services compared to other areas

69. It was also estimated by the integrator that the unit cost per customer was lower compared to home care provided by the city. However, the reliability of these results cannot be evaluated by the researcher as we did not have knowledge on whether the comparisons were made by controlling for e.g. demographic structure and morbidity of the different areas of the city. Thus, we can only speculate if the contract has influenced the Kotitori providers' performance in a way the city would have expected. In addition, these numbers tell only what has happened to the use of the services. They do not say anything about the need for the services.

70. If we look at the age structure in different areas of the city (Figure 11), we can observe that in the central are, i.e. Kotitori responsibility area, there is a larger proportion of those citizens aged 65 and over as well as those aged 75-84 and 85 and over. The results presented by Kotitori may indicate thus two things. It may be that Mawell has been able to cut the unnecessary use of the above mentioned services. In this case the performance of the Kotitori providers has been superior to those of public providers. However, the age structure of the are lets us also speculate with the option that the incentives has also worked as barriers to receive e.g. secondary care or sheltered housing services also in cases the use of these services would be necessary. Potentially these cases are among the minority, but this possibility is good to have in mind as the contract and its impact is evaluated. If the contract has also worked in this direction, it is not of benefit of the city nor of the customers.

Figure 11. The age structure in the different areas of Tampere in 2011 (City of Tampere)



71. As to the differences between the own home care provider of the city and Kotitori it was also mentioned that the role of the contract is different in the city organisation and in Kotitori. The case managers described that the contract directs their operations and also the operations of the home care contractors of Kotitori. In turn, the employees in the own home care provision of the city were seen rarely aware of the content of the contract or do not "respect what has been agreed upon". Indeed, also the

purchasing manager saw that in Kotitori model the contract has an important role as a steering mechanism. Thus, for the city the integrator model potentially works as a tool for stronger steering power via the contract.

Private providers

Integrator services

72. As most of the home care and home help providers are small or medium sized firms, their negotiation power towards the city is alone rather small. In the Kotitori model, the integrator is able to collect the wishes and needs of the small providers and bring them forth in the city administration. The integrator is potentially better heard by the city compared to small local private providers as it works in a close partnership with the city. By strengthening their voice towards the city the Kotitori model benefits especially the small providers.

73. One of the aims behind Kotitori concept was to establish a more coherent network of the providers delivering services for the elderly. For the private providers, it was seen, that a more coherent network would provide possibilities to change ideas and good practices and to search for synergy gains with other providers. Since 2009 the provider network has grown from 0 to 110 private providers. The majority (c. 80 %) of the providers are sole traders or small or medium sized enterprises. Of the network providers 11 % are third sector organisations and 9 % are large companies. Thus, Kotitori has been able to attract especially the small local providers in the network.

74. There were no statistics available on the benefits of Kotitori in a form of new customers for private providers. However, it was estimated by Kotitori that on average 70 % of *new customers* purchase services from private providers, while 30 % are granted municipal home care services. In December 2011 Kotitori engaged with 59 new customers, of which 14 purchased private home care and 29 private support services. This would mean that approximately every fourth provider in the network would have a new customer every month. This lets us assume that the effect on employment in the region is rather marginal. If that is the case, it may be asked if Kotitori is only regarded as one platform of advertising for the providers, not a substantial source of new customers.

Municipal home care services

75. Since recently the big national level for-profit providers have operated mainly in the fields of sheltered housing and health care services. They are, however, increasingly interested also on home care services as they are also the emphasis of the current elderly care policies. One of the aims of the Kotitori model was to support the small, local providers' abilities to compete with the large national level providers on the municipal contracts. The Kotitori model provides a single bidding process from the municipality (that is the procurement of the integrator) but enables the municipality to indirectly support also small providers as the integrator is allowed to sub-contract with several small providers. In theory the idea seems to be feasible. In practice, it is unclear whether the integrator model is able to support the local provision of the services.

76. Currently, Mawell has two sub-contractors that deliver the home care services in the Kotitori's responsibility area: Mediverkko and Nordic Senior Services. Either of them is a local provider. Mediverkko is a national level actor, while Nordic Senior Services provides services in three municipalities in Finland. Both of them are providers that seek growth in the home care market. In the first bid on the municipal home care services organised by the integrator there were national level, regional level and local level providers. However, at least in this bid the local providers did not succeed. This is quite natural as the large providers are likely to have more potential to invest in the development work which is provided in

the contract. In addition, they may also have better competencies to comply with the requirements of efficiency and cost effectiveness of the home care provided by the city. Moreover, the costs of negotiating with several small providers are as costly for the integrator as it is for the city. As there seems not to be an incentive for the integrator to actually support the local provision, the integrator model may not support the local providers in practice.

Municipalities elsewhere in Finland and in other countries

77. The Kotitori model has not yet been transferred to any other municipalities in Finland. However, it was told by Mawell Care that all of the large cities in Finland have been interested in this new model of service delivery. However, in order to be feasible the Kotitori model requires a large enough population base. Tampere is a relatively large city with c. 200 000 inhabitants and thus provides a population base large enough for a service market in which multiple providers may operate and even compete. The context is also urban, which lets one to assume that there is slightly more purchasing power in the population compared to the more rural areas. Thus, the transferability of Kotitori is restricted to the cities with sufficient demand and supply for private home care services.

78. The transferability of the Kotitori model is rather good also internationally. However, in addition to sufficient demand and supply also the market should consist of small providers with diverse service profiles. The model might be beneficial also for countries with interest to develop integrated care as the model has also a potential to integrate the services from both health care and social service sectors.

CONCLUSIONS

79. The main difficulty in evaluating the Kotitori model is a lack of reliable data. In order to say something about the cost-effectiveness of Kotitori model compared to the traditional model the demographic and socioeconomic factors of the elderly population should be taken into account in the analysis. In addition, an attempt should be taken to analyse what has happened to the need for the services among the elderly citizens living in the responsibility area of Kotitori.

80. The integrator model in which the citizens are provided also a possibility to purchase private services creates an opportunity for the city to transfer a part of the costs of care to the citizens. The model makes it increasingly possible for the city to tighten the criteria for the municipal home care services and support services as the citizens access to private services is supported via integrator model. Within this development is has to be ensured that the most vulnerable client groups are not excluded from the system. In its current form the Kotitori model does not yet answer to the major challenge in the Finnish social care system: how to support the access of vulnerable client groups such as old people to services they need and prefer.

81. Kotitori is marketed as a "One stop shop" of the home care services, referring to a market place in which the elderly are provided with information on private services. For the elderly who cannot afford private services Kotitori does not, in its current form, provide added value compared to the traditional system. "One stop shop" does not involve primary and secondary health care services or the service from other sectors of the city. The model might benefit all the citizens better if, in additional to municipal home care services and private services, the elderly were also able to have an access to health care services via Kotitori.

82. The city of Tampere has potentially been one of the biggest beneficiaries of the Kotitori model. The model involves substantial agreement on consultation and development work of the own home care provision of the city. The development work includes the development of the processes and working culture at the systemic level but also development of the technological architecture of the city. In addition, Kotitori model provides the city with a benchmarking opportunity and tool to develop its operations with this knowledge.

83. The Kotitori model benefits especially the small providers by strengthening their voice and increasing their negotiation power towards the city. In addition, a more coherent network provides possibilities to change ideas and good practices and to search for synergy gains with other providers. However, the effect on employment in the region is potentially rather marginal. It may be asked if Kotitori is only regarded as one platform of advertising among the providers, not a substantial source of new customers.

84. Nationally and also internationally, the transferability of the Kotitori model is rather good. However, in order to be beneficial, the market should consist of small providers with diverse service profiles. The model might be beneficial also for countries with interest to develop integrated care as the model has also a potential to integrate the services from several sectors of the society.

DATA

85. The primary data of this case study are X informant interviews conducted in January and February 2012 by the researchers. The informants represent key stakeholders regarding the establishment and operation of Kotitori. The informants represent following stakeholder groups:

- Customers, i.e. senior citizens and their relatives (indirectly)
- Kotitori case managers
- The integrator (Mawell Care and Nordic Health Care Group)
- Administrative level of the city of Tampere (service purchasing director and director of development of wellbeing services)
- Kotitori home care contractors

86. In addition, the researcher have employed their previous knowledge on Kotitori as well as interview data collected for the purposes of another research project to the extent it included information on Kotitori the researchers were provided with the key policy documents concerning the establishment of Kotitori by the city of Tampere. Finally, the researchers have employed the data provided by The Statistics Finland and SOTKAnet-data base.

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APPENDIX I

Figure 1 A basic process of getting home care for an old person in the traditional system

Boxes with grey filling: An active role of the city (municipality)/ the case manager ; Boxes with white filling: Responsibility of the old person

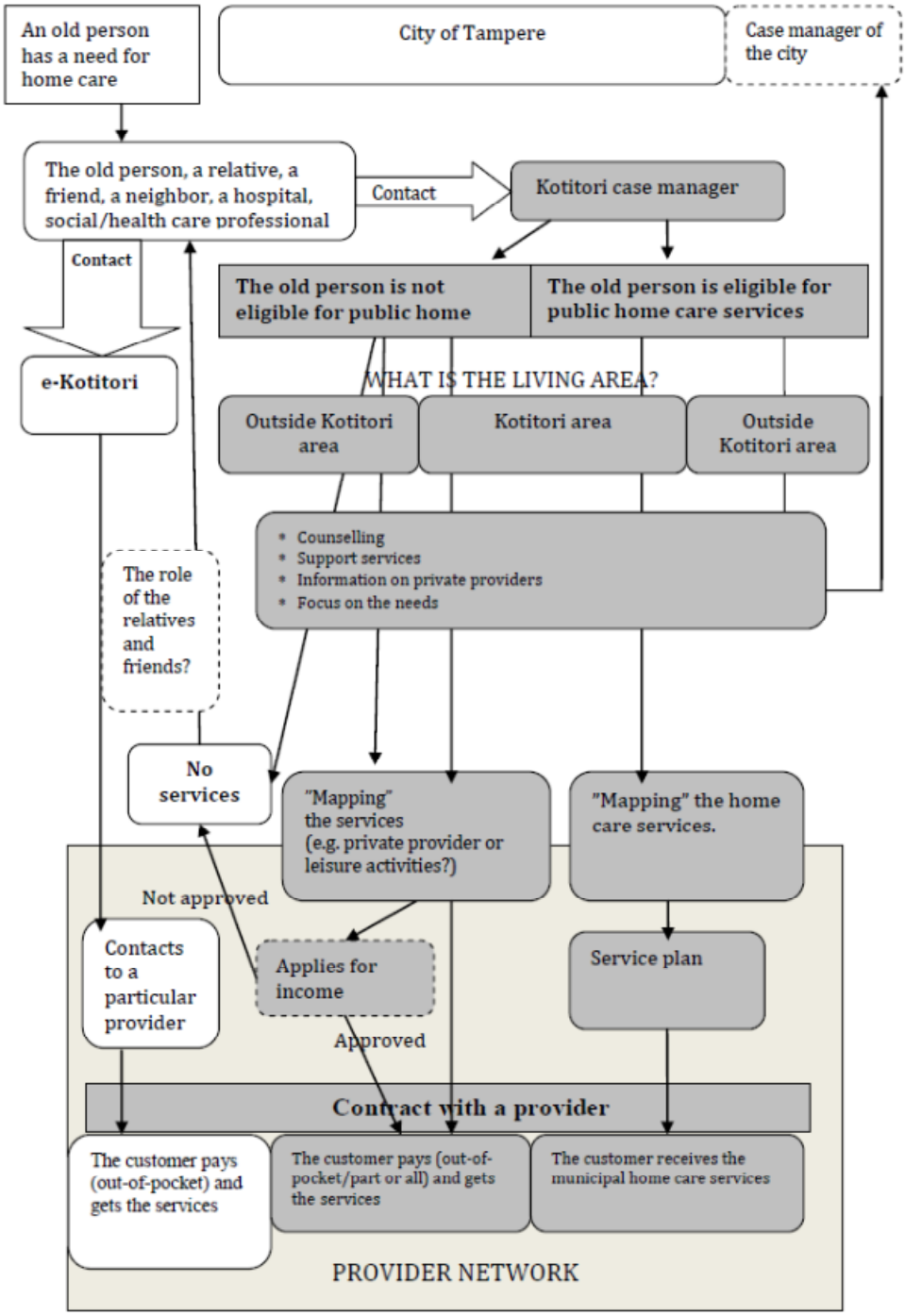

Figure 2 A process of getting home care for an old person in the integrator model

Boxes with grey filling: An active role of the integrator;

Boxes with white filling: Responsibility of the old person